Public

STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

January 7, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ram Swaroop Makker, M.D.

Redacted Address

Terrence J. Sheehan, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

RE: In the Matter of Ram Swaroop Makker, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 09-166) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine **if said license has been revoked, annulled, suspended or surrendered,** together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street-Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
ADMINISTRATIVE REVIEW BOARD FOR PROFESSIONAL MEDICAL CONDUCT

In the Matter of

Ram Swaroop Makker. M.D. (Respondent)

A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)

Administrative Review Board (ARB)

Determination and Order No. 09-166

Before ARB Members D'Anna. Pellman. Wagle. Wilson and Milone
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): Terrence J. Sheehan. Esq.
For the Respondent: Pro Se

Following a hearing below. a BPMC Committee determined that the Respondent practiced with negligence and incompetence on more than one occasion in treating eight patients in hospital emergency rooms. The Committee voted to revoke the Respondent's license to practice medicine in New York State (License). In this proceeding pursuant to New York Public Health Law (PHL) § 230-c (4)(a)(McKinney 2009). the Respondent asks the ARB to nullify that Determination. After reviewing the hearing record and the parties' review submissions. the ARB affirms the Committee's Determination on the charges and the ARB votes 5-0 to affirm the Committee's Determination to revoke the Respondent's License.

Committee Determination on the Charges

The Committee conducted a hearing into allegations that the Respondent violated New York Education Law (EL) §§ 6530(3). 6530(5) & 6530(32) (McKinney 2009) by committing professional misconduct under the following specifications:

- practicing medicine with negligence on more than one occasion,
- practicing medicine with incompetence on more than one occasion, and.

- failing to maintain accurate patient records.

The Petitioner commenced the proceeding by an April 24, 2009 Summary Order from the New York Commissioner of Health, suspending the Respondent's License pursuant to the Commissioner's authority under PHL § 230(12). The charges involved the care that the Respondent provided to eight persons (Patients A-H) at the Emergency Departments (ED) at Mary Immaculate Hospital (Immaculate), Our Lady of Lourdes Hospital (Lourdes) and St. John's Hospital Queens (St. John's), between March 2002 and May 2007. The record refers to the Patients by initials to protect patient privacy. Following the hearing, the Committee rendered the Determination now on review.

The Committee determined that the Respondent practiced with negligence on more than one occasion, incompetence on more than one occasion and that the Respondent failed to maintain accurate patient records.

The Committee found that Patient A presented at the ED at Immaculate covered in diarrhea and with difficulty breathing, altered mental status and unstable vital signs. The Patient's home medications included methadone. The Patient's condition deteriorated over the course of six hours, the Patient suffered cardiac arrest, required resuscitation and was transferred to Critical Care. The Committee found that the Respondent failed to examine the Patient's pupils to check for methadone overdose, failed to check the Patient's lungs despite respiratory distress and failed to check the Respondent's abdomen despite the diarrhea. The Committee found that the Respondent made no intervention for an unstable airway and poor respiratory status and that the Respondent failed to realize the extent of the Patient's sickness. The Respondent failed to re-evaluate the Patient as her status declined. The Committee found that the Patient required a trial of the medication Narcan intravenously or intubation with respiratory support, or both, to reverse respiratory depression. The Respondent provided none of those interventions. The Patient died six days after the presentation in the ED and an autopsy revealed a drug overdose. The Committee concluded that interventions could have prevented the cardiac arrest and that the Respondent could have prevented the Patient's death if the Respondent had followed the accepted standard of care.

Patient B presented at the ED at Immaculate with abdominal pain, abdominal tenderness and nausea and, within thirty minutes from the time the Patient entered the ED, a urine test confirmed a pregnancy. The Committee found that the Patient's presenting condition required an immediate pelvic examination and gynecological consultation to diagnose ectopic pregnancy, due to grave risk for ongoing bleeding and shock if diagnosis and treatment of a ruptured ectopic pregnancy is delayed. The Patient had suffered a ruptured ectopic pregnancy, but the Respondent performed no immediate abdominal examination and no gynecological consultation occurred until eight hours following the Patient's arrival in the ED.

Patient C presented to the ED at Lourdes with abdominal pain and tenderness following an injury at a soccer game. The Committee found that the Respondent failed to perform a proper abdominal examination or order a CT scan for trauma in the abdomen. The Respondent released the Patient after an hour, but the Patient returned to a different hospital shortly thereafter with increased pain, dizziness and near syncope. A CT scan revealed a ruptured spleen. The Committee found the Respondent responsible for delaying treatment for Patient C.

Patient D presented at the ED at St. John's with mid-abdominal pain for one day that had gotten worse over time. The Respondent discharged the Patient without ordering a CT scan of the pelvis and abdomen to check for acute appendicitis and without ordering a surgical consult. The Committee found that the failure to order the consultation and scan departed from the standard of care and the Committee found the Respondent's testimony at hearing demonstrated a deficient understanding of the disease process.

Patient E presented at the ED at Lourdes complaining of bilateral kidney pain. Tests revealed abnormal liver functions unrelated to the kidneys, but rather related to alcoholism and liver disease. The tests also revealed the possibility of a serious infection or inflammatory condition. The Committee found that the Respondent acted inappropriately by failing to order an abdominal ultrasound, to refer the Patient for follow-up related to acute liver disease and to give instructions about alcohol consumption.

Patient F, a nine year old child, presented at the ED at Immaculate with a fever, back pain and sore throat. The Respondent proceeded with a working diagnosis of meningitis, ordered a

CAT scan and ordered the Patient transferred to a pediatric hospital for evaluation. The Committee found that the Patient presented with no symptoms for meningitis and found that a proper test for meningitis would be a spinal tap rather than a CAT scan. The Committee found that the Patient did display an elevated heart rate and acute pharyngitis, which raised the concern for dehydration. The Committee found that the Respondent failed to order appropriate fluids to restore volume. The Committee also found that, if the Patient was suffering from meningitis, the Respondent would have wasted life saving time in ordering the CAT scan.

Patient G, an eight-month-old child, presented at the ED at Lourdes with a history for vomiting and diarrhea, with a low-grade fever. The vomiting ended after the Patient received pedialyte and the Patient was alert and in good condition upon discharge. The Respondent ordered that the Patient receive the medication, Phenergan, rectally at the ED and that the Patient receive Phenergan by suppository upon discharge. The Committee found that the United States Food and Drug Administration issued a black box warning concerning the danger for respiratory distress in children under two years old from the use of Phenergan and the Committee concluded that Phenergan was contraindicated for use in Patient G. The Committee found that a safer alternative medication, Tigan, was available in the ED during the treatment for Patient G. The Patient never received Phenergan because the pharmacy at Lourdes caught the error. The Committee also found that the Respondent discharged Patient G without confirming that the Patient had become adequately rehydrated and that the Respondent's medical record for Patient G contained unexplained and confusing discrepancies.

Patient H presented to the ED at Lourdes following a fall at a nursing home. The patient's history included dementia and multiple medical problems. The Respondent ordered x-rays and other tests, but discharged the Patient prior to the time that the radiologist reviewed all the x-rays. The radiologist's review revealed a femoral neck fracture and the Patient needed to return to Lourdes for treatment. The Committee found that the Respondent interpreted an x-ray inappropriately and that the Respondent failed to consult with the radiologist on the x-rays for the Patient.

In making their findings, conclusions and determinations on the charges, the Committee relied on medical records in evidence and on testimony from the Petitioner's expert witness, Mark S. Silberman, M.D. Dr. Silberman practiced emergency medicine and taught at Columbia University Medical Center. The Committee found Dr. Silberman, impressive and thorough as a witness, although sometimes academic and rigid. The Committee also found the mother of Patient C testified credibly as a fact witness. The Committee found that testimony by the Respondent lacked credibility. The Committee found that the Respondent lied in several instances in his testimony. The Committee noted that the Respondent testified that he examined Patient C while the Patient was undressed. The Committee found the mother of Patient C credible in her testimony that the Respondent did not have the Patient undress when the Respondent examined the Patient. The Respondent testified that he prescribed Phenergaan for Patient G only because Tigan, the medication the Respondent preferred, as unavailable at the Lourdes ED. The Committee found that records established that Tigan was available. The Respondent testified that he saw the pelvic x-ray on Patient H before discharging the Patient. The Committee found that the Respondent never bothered to read the x-ray, because the x-ray showed a change of alignment and abnormality. The Committee also found that the Respondent failed or refused to acknowledge inconsistencies during his testimony.

The Committee voted to revoke the Respondent's License. The Committee stated that the Respondent failed to ensure patient safety in all eight cases at issue and the Committee found that the eight cases represented the most common emergency room situations. The Committee faulted the Respondent for inadequate physical examinations and thought processes, shoddy diagnoses and processes, poor record keeping and a serious lack of engagement with patients. The Committee also found that the Respondent lied in testimony, expressed no remorse and blamed others for his mistakes. The Committee concluded that retraining would provide no correction for those deficiencies. The Committee also rejected practice in a supervised setting as a remedy. The Committee ended their Determination by expressing the belief that the Respondent would remain a threat to public safety if he remains in practice.

Review History and Issues

The Committee rendered their Determination on September 3, 2009. This proceeding commenced on September 29, 2009, when the ARB received the Respondent's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Respondent's brief and the Petitioner's reply brief. The record closed when the ARB received the reply brief electronically on October 22, 2009. The Respondent sought to make submissions to the ARB in addition to his review brief, but PHL § 230-c permits no such additional submissions.

The Respondent argued that the Committee made incorrect findings and the Respondent asked the ARB to reconsider the Committee's Determination and to overturn the revocation. The Respondent stated that he worked in hospitals in deteriorating conditions, with limited resources and back-up and sub-optimal infrastructure. In some instances, the Respondent reargued findings by the Committee and made reference to medical literature, which the Respondent submitted with his brief. In other instances the Respondent reargued factual findings by the Committee. For example, the Respondent argued that he considered Methadone overdose for Patient A, but failed to make that indication in the medical record. The Respondent's brief conceded that his "charting" was poor. As a further example, in the case of Patient C, the Respondent argued that the Patient's abdomen was uncovered during the examination. As a final example, in the Case of Patient G, the Respondent argued that he ordered Phenergan because his first choice, Tigan, was unavailable. The Respondent concedes that he erred in prescribing Phenergan as a discharge medication, but he contended that such an error provides insufficient grounds on which to revoke the Respondent's License.

The Petitioner replied that the Respondent's brief constituted a re-argument of the same issues that the Committee resolved at the hearing. The Petitioner contended that the Respondent made no showing that any finding by the Committee lacked support in the record, but instead argued only that the Committee should have found otherwise. The Petitioner argued that the Respondent's brief provided insufficient grounds on which to reverse the Committee. The Petitioner also pointed out that the Respondent's brief contained material from outside the hearing record.

ARB Authority

Under PHL §§ 230(10)(i), 230-c(1) and 230-c(4)(b), the ARB may review Determinations by Hearing Committees to determine whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law and whether the Penalty is appropriate and within the scope of penalties which PHL §230-a permits. The ARB may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd., 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993); in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS 2d 759 (3rd Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). The ARB may choose to substitute our judgment and impose a more severe sanction than the Committee on our own motion, even without one party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of

society, rehabilitation and deterrence. Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 415 (1996).

The statute provides no rules as to the form for briefs, but the statute limits the review to only the record below and the briefs [PHL § 230-c(4)(a)], so the ARB will consider no evidence from outside the hearing record. Matter of Ramos v. DeBuono, 243 A.D.2d 847, 663 N.Y.S.2d 361 (3rd Dept. 1997).

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only pursuant to statute or agency rules. Rooney v. New York State Department of Civil Service, 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Westchester Co. Sup. Ct. 1984). The provisions in PHL §230-c provide the only rules on ARB reviews.

Determination

The ARB has considered the record and the parties' briefs, except we have given no consideration to the material that the Respondent submitted from outside the record. The ARB affirms the Committee's Determination that the Respondent practiced with negligence and incompetence on more than one occasion and that the Respondent failed to maintain accurate records. The ARB votes 5-0 to affirm the Committee's Determination to revoke the Respondent's License.

The provisions on administrative review at PHL § 230-c(4)(a) permit the party seeking review to file a brief and permit the adverse party to file a reply brief. The reply brief closes the record on review. In this case, the Respondent sought to file additional written submissions following the Petitioner's reply. The ARB considered only the Respondent's brief and the

Petitioner's reply brief and the ARB gave no consideration to an additional submission by the Respondent. The Respondent's review brief also attached a large amount of documentation from outside the hearing record. The ARB does not consider such material from outside the record, because such material was not before the Committee when the Committee rendered the Determination on review and because the other party had no chance to challenge that material at the hearing. Ramos v. DeBuono, 243 A.D.2d 847, 666 N.Y.S.2d 361 (3rd Dept. 1997).

The Respondent's brief conceded to poor "charting". That concession and the Committee's findings on the Respondent's record keeping demonstrate that the Respondent failed to maintain accurate patient records. The Respondent also conceded that he erred in prescribing Phenergan as a discharge medication for Patient G. The Petitioner charged that the Phenergan discharge prescription constituted both practicing with negligence and practicing with incompetence.

The ARB finds that the evidence the Committee found credible also established that the Respondent practiced with negligence and incompetence in the treatment for Patient G at the Lourdes ED and in the treatment for all the other Patients. The Committee found the expert testimony by Dr. Silberman, the fact testimony by the mother of Patient G and the medical records in evidence provided a preponderance of the evidence to establish that the Respondent failed to practice according to accepted standards and that the Respondent demonstrated a lack of skill or knowledge necessary to practice medicine safely. In challenging that evidence at the hearing, the Respondent relied on his own testimony, which the Committee found untrustworthy. The Respondent claimed that he did consider methadone overdose in Patient A, but the chart failed to note that the Respondent considered an overdose. The ARB finds no error by the Committee to assume that if there is no documentation of such consideration in a medical chart.

then no such consideration took place. The Respondent claimed that he examined Patient C with the Patient's abdomen uncovered, but the Patient's mother testified that the Patient remained dressed. The Committee accepted the testimony by the Patient's mother. The Respondent claimed that he prescribed Phenergan for Patient G in the ED, because Tigan was unavailable. The records for the ED showed that Tigan was available. The ARB defers to the Committee, as the fact-finder, in the Committee's judgment on credibility in making the three findings we have just discussed and in making the other extensive and thoughtful findings in their Determination. The ARB finds no error by the Committee for relying on other evidence and rejecting the Respondent's explanation for events.

The ARB affirms the Committee's Determination to revoke the Respondent's License. The Respondent attempted to shift the blame for his misconduct to others, but the Committee found the Respondent responsible. The ARB agrees. The Respondent's misconduct occurred at three different hospitals over the course of five years. The misconduct involved eight different people, with conditions that the Committee found to be the most common emergency room situations. The Committee found inadequate examinations, shoddy diagnoses and practice, a lack of understanding or knowledge concerning disease processes and medications and a lack of engagement with patients. The Committee rejected retraining as a possible sanction. The ARB agrees with the Committee that the Respondent presents as a poor candidate for retraining, because the Respondent refused to admit almost all his errors and because he refused to accept responsibility for his mistakes. The ARB agrees further with the Committee that restriction to practice in an institutional setting would provide no safe alternative, because the Respondent's misconduct occurred in the institutional setting at three different hospitals. Finally, the ARB agrees again with the Committee that the pattern of misconduct that the Respondent displayed in

the eight cases at issue will be repeated if the Respondent resumes practice in New York State. The ARB concludes that the Respondent has demonstrated his unfitness to practice medicine in New York State.

ORDER

NOW, with this Determination as our basis, the ARB renders the following ORDER:

1. The ARB affirms the Committee's Determination that the Respondent committed professional misconduct.
2. The ARB affirms the Committee's Determination to revoke the Respondent's License.

Thea Graves Pellman
Dana G. Wagle, M.D.
Linda Prescott Wilson
John A. D'Anna, M.D.
Richard D. Milone, M.D.

In the Matter of Ram Swaroop Makker, M.D.

Linda Prescott Wilson, an ARB Member concurs in the Determination and Order in the Matter of Dr. Makker.

Dated: [illegible], 2009

Redacted Signature

Linda Prescott Wilson

In the Matter of Ram Swaroop Makker, M.D.

Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Makker.

Dated: Jan. 5, 2010

Redacted Signature

Thea Graves Pellman

In the Matter of Ram Swaroop Makker, M.D.

Datta G. Wagle, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Makker.

Dated: 12/30/, 2009

Redacted Signature

Datta G. Wagle, M.D.

In the Matter of Ram Swaroop Makker, M.D.

Richard D. Milone, an ARB Member concurs in the Determination and Order in the Matter of Dr. Makker.

Dated: December 28, 2009

Redacted Signature

Richard D. Milone, M.D.

In the Matter of Ram Swaroop Makker, M.D.

John A. D'Anna, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Makker.

Dated: 2-27-09, 2009

Redacted Signature

John A. D'Anna, M.D.